DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/02/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED. STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X8) DATE SURVEY A BUILDING _ COMPLETED 445205 B. IVING NAME OF PROVIDER OR SUPPLIER 01/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE CONSULATE HEALTH CARE OF CHATTANOOGA 8249: STANDIFER GAP ROAD CHATTANOOGA, TN 37421 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X6) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE FREFIX TAG DEFICIENCY) F 000 INITIAL COMMENTS . Preparation and/or execution of this i F 000 plan of correction does not constitute A recertification survey and complaint admission or agreement by the Investigation #39706, #40137, #40236, #40293, provider with the statement of #40321, #40385, #39812, and #40386 were deficiencies. The plan of correction is conducted from 1/8/17 through 1/19/17 at Consulate Health Care of Chattanooga. No prepared and/or executed because it is deficiencies were eited related to the complaints. required by provision of Federal and F 282 483.21(b)(3)(II) SERVICES BY QUALIFIED F 282 PERSONS/PER CARE PLAN 88≓0 State regulations. (b)(3) Comprehensive Care Plans F282 483.21(c)(3)(ii) Services By The services provided or arranged by the facility, 2/17/17 Qualified Persons/Per Care Plan as outlined by the comprehensive care plan, must-1. Resident #1 care plan reviewed (ii) Be provided by qualified persons in and/or updated on 2/7/2017 to reflect accordance with each resident's written plan of resident's current fall interventions by care. This REQUIREMENT is not met as evidenced the Director of Clinical Services. Based on medical record review, review of facility 2. Observations of current residents at investigations, interview, and observations, the risk for falls was completed 2/6/2017facility falled to implement the care plan Interventions for prevention of falls for 1 resident 2/9/2017 to validate current fall (#1) of 5 residents reviewed for falls, of 45 interventions, based on the care plan sampled residents, resulting in a head laceration were in place by the Director of Clinical requiring sutures (harm) for Resident #1. Services and/or Nursing Supervisor. The findings included: No issues identified. Medical record review revealed Resident #1 was 3. The Director of Clinical Services admitted to the facility on 4/10/15 with diagnoses Including Senlie Dementia, Diabetes Mellitus and/or Nursing Supervisor in serviced Type 2, Hypertension, Chronic Kidney Disease, current Certified Nurse Assistants, Diverticulitis, and Depressive Disorder. Licensed Nurses on making sure that Medical record review of the Annual Minimum fall interventions are in place on Data Set (MDS) dated 6/19/16 revealed Resident residents at risk for falls based on the

Any deficiency statement ending with an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2687(02-99) Previous Versions Obsolote

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Event ID: 21L911

Facility ID: TN9314

TITLE

(X8) DATE

EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2 MULTIPLE CONSTRUCTION A. EUILDING			(X3) DATE SURVEY COMPLETED	
. 445206		B. VIING			0414010047	
ATE HEALTH CARE (8249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421	ODE	/19/2017	
(EACH DEFICIENCY	MUST BE PRECEDED BY FILL		X (EACH CORRECTIVE ACTION)	SHOULD BE	COMPLETION DATE	
#1 had a Brief Intense score of 8 out of a proderate cognitive revealed the resider assistance of one pullving. Medical record reviee 7/1/16 revealed " Scall light is within resident to use it for [wheelchair] alam Medical record reviee 9/10/16 at 7:50 PM, the floor in front of high the center of her head medical record reviee 9/11/16 at 3:35 AM, facility via EMS [Emestitches to forehead [dressing]" Review of a facility in revealed " Date of 09/10/16 Locomotion bound Transfer stall in W/C in her room ER [Emergency Roolaceration to head" Investigation reveale to have a pressure a wheelchair at the tim 7/1/16. Telephone interview "Telephone interview"	where for Mental Status (BIMS) cossible 15, which Indicated impairment. Continued review at required extensive erson for all activities of daily who fit the care plan dated safetyBe sure the resident's ach and encourage the assistance as neededW/C " who fit a nurse's note dated revealed "found lying on er W/C with a laceration in ad" who fit a nurse's note dated revealed "Returned to ergency Medical Services] of covered with drag hostigation dated 9/13/18 Decourrence in Status: VV/C [wheel chair] has extensive assistsitting Summary: Resident sent to m] status post fall with Further review of the difference in the ersident was supposed larm in place in the erident was care planned with Certified Nursing	F 2.	care plan/kardex 2/8/2017- Future employees will be in on this during orientation be Development Coordinator. Director of Clinical Services Nursing Supervisor will perf Quality Improvement Monir residents at risk for falls for interventions being in place 2/14/2017 5 times a week for itimes a week for 1 month at monthly thereafter for one will be reported the Quality Assurance Performant Committee or 2/10/2017. The results of the Monitoring will be reported Quality Assurance Performant Improvement Committee memonthly for three months the quarterly thereafter for a year Quality Assurance Performant Improvement Committee memonthly for three months the quarterly thereafter for a year Quality Assurance Performant Improvement Committee memonthly for three months the quarterly thereafter for a year Quality Assurance Performant Improvement Committee memonthly for three months the quarterly thereafter for a year Quality Assurance Performant Improvement Committee memonths to but not limited to executive Director, Director of Executive Director, Director	y the Staff The and/or form toring of fall beginning or 1 1 month, 2 nd then year. rvices ection to rmance n is quality to the nce embers nen ar. The nce embers the of Clinical		
Was With Resident#1	after the fall on 9/10/16,		Services, Unit Manager, Staff	·		
	PROVIDER OR SUPPLIER ATE HEALTH CARE (SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa, #1 had a Brief Internation of the resider assistance of one poliving. Medical record reviee 7/1/16 revealed " Social light is within resident to use it for [wheelchair] alarm Medical record reviee 9/10/16 at 7:50 PM, the floor in front of hith the center of her head facility via EMS [Eme stitches to forehead [dressing]" Review of a facility in revealed " Date of 0 9/10/16 Locomotion bound Transfer stallin W/C in her room ER [Emergency Roo laceration to head" Investigation revealed wheelchair at the tim 7/1/16. Telephone interview of Assistant (CNA) #8 of the content	ATE HEALTH CARE OF CHATTANOGA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 #1 had a Brief Interview for Mental Status (BIMS) score of 8 out of a possible 15, which indicated moderate cognitive impairment. Continued review revealed the resident required extensive assistance of one person for all activities of daily living. Medical record review of the care plan dated 7/1/16 revealed "SafetyBe sure the resident's call light is within reach and encourage the resident to use it for assistance as neededW/C [wheelchair] alamm" Medical record review of a nurse's note dated 9/10/16 at 7:50 PM, revealed "found lying on the floor in front of her W/C with a laceration in the center of her head" Medical record review of a nurse's note dated 9/10/16 at 5:35 AM, revealed "Returned to facilify via EMS [Emergency, Medical Services]stitches to forehead covered with drsg [dressing]" Review of a facility investigation dated 9/13/16 revealed "Date of Occurrence 9/10/16Locomotion Status: VV/C [wheel chair] boundTransfer status: extensive assiststiting in W/C in her roomSummary: Resident sent to ER [Emergency Room] status post fall with laceration to head" Further review of the investigation revealed the resident was supposed to have a pressure alarm in place in the wheelchair at the time of the fall, as care planned 7/1/16. Telephone interview with Certified Nursing Assistant (CNA) #8 on 1/12/17 at 10:35 AM, who was with Resident #1 after the fall on 9/10/16,	#45205 B. WING #A EUILD #445205 B. WING PROVIDER OR SUPPLIER ATE HEALTH CARE OF CHATTANOOGA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 #1 had a Brief Interview for Mental Status (BIMS) socre of 8 out of a possible 15, which indicated moderate cognitive impairment. Continued review revealed the resident required extensive assistance of one person for all activities of daily living. Medical record review of the care plan dated 7/1/1/16 revealed ",Safety,Be sure the resident's cell light is within reach and encourage the resident to use it for assistance as needed,W/C [wheelchair] elam" Medical record review of a nurse's note dated 9/10/16 at 7:50 PM, revealed "found lying on the floor in front of her W/C with a laceration in the center of her head" Medical record review of a nurse's note dated 9/10/16 at 7:50 PM, revealed "Returned to facility via EMS [Emergency, Medical Services]stitches to forehead covered with drsg [dressing]" Review of a facility investigation dated 9/13/16 revealed "Date of Occurrence 9/10/16Locomotion Status: W/C [wheel cheir] boundTransfer status: extensive assistsitting in W/C in her roomSummary. Resident sent to ER [Emergency Room] status post fall with laceration to head" Further review of the investigation revealed the resident was supposed to have a pressure alarm in place in the wheelchair at the time of the fall, as care planned 7/1/16. Telephone interview with Certified Nursing Assistant (CNA) #8 on 4/12/17 at 10:35 AM, who was with Resident #1 after the fall on 9/10/16,	### ATE HEALTH CARE OF GHATTANOGA SIMMANY STAYEMENT OF DEPRICENCIES (ACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USE DEPARTMENT IN BURYCHARTON) Continued From page 1 ### had a Brief Interview for Mental Status (BIMS) socre of 8 out of a possible 15, which Indicated moderate cognitive impairment. Continued review revealed the resident required extensive assistance of one person for all activities of daily living. Medical record review of the care plan dated 9/10/16 at 7:50 PM, revealed "SafelyBe sure the resident to use it for assistance as neededW/C [wheelchair] alamm" Medical record review of a nurse's note dated 9/10/16 at 7:50 PM, revealed "Returned to facility via EMS [Emergency Medical Services]stitches to forehead covered with drag [dressling]" Medical record review of a nurse's note dated 9/10/16 at 3:55 AM, revealed "Returned to facility via EMS [Emergency Medical Services]stitches to forehead covered with drag [dressling]" Medical record review of a nurse's note dated 9/10/16 at 7:50 PM, revealed "Returned to facility via EMS [Emergency Medical Services]stitches to forehead covered with drag [dressling]" Medical record review of a nurse's note dated 9/10/16 at 7:50 PM, revealed "Returned to facility via EMS [Emergency Medical Services]stitches to forehead covered with drag [dressling]" Medical record review of a nurse's note dated 9/10/16 at 3:55 AM, revealed "Returned to facility via EMS [Emergency Medical Services]stitches to forehead covered with drag [dressling]" Medical record review of a facility via EMS [Emergency Room of the facility via EMS [Emergency Room of	ATE HEALTH CARE OF CHATTANOOGA SUMMARY STATEMENT OF DEPOLICATION SUMMARY STATEMENT OF DEPOLICATION SUMMARY STATEMENT OF DEPOLICATION (EACH DEPOLICATION TO PERCENDIORS) (EACH DEPOLICATION TO PERCENDIORS OF THE PERCEN	

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: 1		445205	B, WING		D4	M0/0047
	PROVIDER OR SUPPLIER ATE HEALTH CARE (OF CHATTANOOGA	† 1	BTREET ADDRESS, CITY, STATE, ZIP CODE 1249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421	1 .07	<u>/19/2017</u>
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F 282	confirmed Resident alarm in the wheeld CNA#8 could not re reach. Interview with Licent 1/17/17 at 12:30 Ply confirmed Resident the fall on 9/10/16 kinterventions to preview of a pressure. The fallure to ensure were implemented to	ge 2 #1 did not have a pressure hair at the time of the fall and ecall if the call light was within sed Practical Nurse #7 on f, in the conference room, #1's care plan at the time of tentified the need for yent falls, which included the alarm in the wheelchair. e the care plan interventions to prevent falls resulted in a ration requiring sultures for	F 282	Continued from page 2 Development, Activities, Medical Director, Social Services, Mainten Director, Dietary Manager and Minimum Data Set Coordinator.	ance 1	
\$ 5 4.0	483.25(d)(1)(2)(n)(1) HAZARDS/SUPER\ (d) Accidents. The facility must ensident environ accident hazar (2) Each resident reand assistance deviation - Bed Rails. The appropriate alternation bed rail. If a bed or must ensure correct	sure that - Ironment remains as free ds as is possible; and ceives adequate supervision ces to prevent accidents. facility must attempt to use ves prior to installing a side or side rall is used, the facility Installation, use, and rails, including but not limited	F 323	F323 483.25(d)(1)(2)(n)(1)-(3) Free Accident Hazards/Supervision/Devices 1. Resident #1 care plan reviewed and/or updated on 2/6/2017 to represidents current fall interventions the Director of Clinical Services. Observations of residents care plan interventions from falls by the Director of Clinical Services was completed 2/6/17 with no issues identified. Resident #48 dycem was replaced wheelchair on 1/11/2017 by the Director of Clinical Services.	flect s by n ector/	2/17/17

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445208 B. LYING	3	01/19/2017	
NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF CHATTANOOGA	STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CHATTANOOGA, TN 87421	(VI) IGIAV IF	
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(1) Assess the resident for risk of entrepment from bed relis prior to installation. (2) Review the fisks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, interviews, and observations, the facility falled to ensure assistive devices were in place to prevent falls for 2 residents (#1, #48) of 5 residents reviewed for falls, of 45 sampled residents, resulting in a head laceration which required sutures (harm) for Resident #1. The findings included: Medical record review revealed Resident #1 was admitted to the facility on 4/10/15 with diagnoses including Senille Dementia, Diabetes Mellitus Type 2, Hypertension, Chronic Kidney Disease, Diverticulitis, and Depressive Disorder. Medical record review of Resident #1's annual Minimum Data Set (MDS) dated 6/19/16 revealed Resident #1 scored a 8 out of 15 on the Brief interview for Mental Status (BIMS), which indicated the resident had moderate cognitive impairment. Continued review revealed the resident required extensive assistance with all activities of daily living with 1 staff person to assist. Medical record review of the care plan dated 7/1/16 revealed "SafetyBe sure the resident's	Continue from page 3 2. Observations of current resident risk for falls was completed 2/6/20 2/9/2017 to validate current fall Interventions based on the care playere in place by the Director of Cli Services and/or Nursing Supervisor No issues identified. 3. The Director of Clinical Services and/or Nursing Supervisor in service Current Certified Nurse Assistants, Licensed Nurses on making sure the fall interventions are in place on residents at risk for falls based on the care plan/kardex 2/8/2017-2/15/20 Future employees will be in service on this during orientation by the St Development Coordinator. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring or residents at risk for falls for fall Interventions being in place beginn 2/14/17, 5 times a week for 1 month, 2 time week for 1 month and then monthit thereafter for one year. 4. The Director of Clinical Services	on inical r. ced the O17. ced traff	

AND PLAN-C	of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2-MULTIPLE CONSTRUCTION A. E-UILDING		(X3) DATE SURVEY COMPLETED	
	‡	445205	B. I VING		04/46/0047	
;	PROVIDER OR SUPFLIER ATE HEALTH CARE (OF CHATTANDOGA	8	BTREET ADDRESS, CITY, STATE, ZIP CODE 1249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421	01/19/2017	
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3	call light is within re resident to use it for [wheelchair] alarm Medical record revise 9/10/16 at 7:50 PM, the floor in front of it the center of her her bedical record revise department record of PM) revealed "Lac Repairsubcutance Skin layer closed, grinterrupted" Medical record revise 9/11/16 at 3:35 AM, facility via EMS [Em transferred into bedicovered with drag [covered w	ach and encourage the assistance as neededW/C " ew of the nurses note dated revealed "found lying on ser W/C with a laceration in ad" ew of a hospital emergency dated 9/10/16 at 23:13 (11:18 peration-Single pus fascia closed3 sutures, reater than 10 sutures ew of a nurse note dated revealed "Returned to ergency Medical Services]stitches to forehead lressing]" nivestigation dated 9/13/16 Occurrence in Status: W/C [wheelchair] itus: extensive assistcall pressure alarm[Indicating ould have been in place at ere a call bell and pressure y, event, environmentwas prior to the fall or at time of in her roomSummary: [Emergency Room] status	F 323	introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/10/2017. The results of this qual monitoring will be reported to the Quality Assurance Performance Improvement Committee member monthly for three months then quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee member consist of but not limited to the Executive Director, Director of Clin Services, Unit Manager, Staff Development, Activities, Medical Director, Dietary Manager and Minimum Data Set Coordinator.	e ity	

Statement and Plan (PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. EUILDING			(X3) D	(X3) DATE SURVEY COMPLETED	
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CONSUL	PROVIDER OR SUPPLIER		·	8249 STANDIFE	89, City, State, Zip Co ER Gap Road Ga, TN 37421	DDE	1/19/2017	
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	Interview with Licent on 1/17/17 at 12:30 confirmed Resident pressure alarm in heat the time of the fa. The fallure to ensurfalls were in place in laceration requiring. Medical record revisal admitted to the faciling Disturbances, Abnooled Schizophrenta. Medical record revisal MDS dated 10/30/16 severe cognitive imprevealed the resident transfers, dressing, bathing with 1-2 per Review of a facility in revealed the resident wheelchair and no in the fall. Continued in further falls, the Interpretation 1/17/16/16/16/16/16/16/16/16/16/16/16/16/16/	chair at the time of the fall, and secall if the call light was within the fall. I sed Practical Nurse (LPN) #7 PM, in the conference room, the fall was supposed to have a ser wheelchair to prevent falls if on 9/10/16. The assistive devices to prevent esuited in a fall with a head sutures for Resident #1. The revealed Resident #48 was lity on 4/4/08 with diagnoses without Behavioral rmal Posture, Contracture, The of Resident #48's quarterly revealed the resident had bairment, Continued review at was totally dependent for eating, personal hydene and	F2	23	DEFICIENCY)			
	care plan was updat Intervention for fall b	w revealed Resident #48's ed to reflect the new revention, "Safetydycem W/C [wheel chair] seat"						

STATEMENT AND PLAN (MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2 MULTIPLE CONSTRUCTION A FUILDING			(X3) DATE SURVEY COMPLETED	
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CONSUL	PROVIDER OR SUPPLIER ATE HEALTH CARE		,	STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421	<u> </u>	10)2017	
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F 323	Gontinued From pa		F 323				
	ithe 200 hallway, rev [Resident#48] is su his wheelchalr seat		5 5 5 5 5 5				
	Observation of Resident #48 with the Director of Nursing (DON) on 1/11/17 at 2:05 PM, in the resident's room, confirmed there was no dycem in the resident's wheelchair seat.						
	ner office, confirmed safety devices were for Resident #1 white head laceration required.	ON on 1/18/17 at 8:35 AM, in the facility falled to ensure in place at the time of the fall ch resulted in a fall with a liking stitches (harm) for led to ensure safety devices sident #48.					
F 502 SS=D	Refer to F282 483.50(a)(1) ADMIN		F 602	F502 483.50(a)(1) Administration		2/17/17	
	(1) The facility must services to meet the facility is responsible of the services. This REQUIREMEN	This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, he facility falled to ensure laboratory tests were completed for 1 resident (#58) of 45 residents eviewed.		Resident #58 physician was not on 1/18/17 of the missing labs by Assistant Director of Clinical Service New orders were obtained.	y the	į	
	Based on medical r the facility falled to e completed for 1 resi reviewed.			2. The Director of Clinical Services and/or Nursing Supervisor reviews the last 90 days worth of lab order validate results obtained 1/30/201	ed		
	The findings include Medical record ravie	d: w revealed Resident#58 was		3. The Director of Clinical Services and/or Nursing Supervisor in services	ced	·	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/02/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** OMB NO. 0938-0391 9#ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/OUPPLIER/CLIA (X2; MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. EUILDING COMPLETED 445205 8, V/ING 01/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CONSULATE HEALTH CARE OF CHATTANOOGA CHATTANOOGA, TN 37421 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID Prefix (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) Continued from page 7 F 502 Continued From page 7 F 602 current licensed nurses on processing admitted to the facility on 12/27/11 with diagnoses. orders for labs 2/8/2017-2/15/2017. including Conduct Disorder, Acute Respiratory Fallure, Convulsions, Psychosis, Major Future employees will be in serviced Depressive Disorder, Anxiety Disorder, and on this during orientation by the Staff (Hypartension. Development Coordinator, The Medical record review of the Physician's Director of Clinical Services and/or Recapitulation Orders dated December 2018, Nursing Supervisor will perform revealed "...CBC [Complete Blood Count], CMP [Complete Metabolic Panel] Every 6 months (Jun Quality improvement Monitoring of [June]/Dec [December])...Valproic Acid Level labs ordered and results beginning every 3 months (March/June/Sept 2/14/17, 5 times a week for 1 month, 3 [September]/Dec)..." times a week for 1 month, 2 times a Medical record review revealed there were no week for 1 month and then monthly laboratory results for December. thereafter for 1 year. Interview with the Assistant Director of Nursing on 1/18/17 at 3:40 PM, in the conference room, 4. The Director of Clinical Services confirmed the CBC, CMP, and Valproic Acid level were not done in December 2016. Introduced the plan of correction to 483.70(f)(1)(5) RES F 514 F 514 the Quality Assurance Performance RECORDS-COMPLETE/ACCURATE/ACCESSIB SS=D Improvement Committee on 2/10/2017. The results of this quality (i) Medical records. monitoring will be reported to the (1) In accordance with accepted professional **Quality Assurance Performance** standards and practices, the facility must maintain medical records on each resident that Improvement Committee members aremonthly for three months then (i) Complete; quarterly thereafter for a year. The Quality Assurance Performance (ii) Accurately documented: Improvement Committee members (iii) Readily accessible; and consist of but not limited to the Executive Director, Director of Clinical

(iv) Systematically organized

Services, Unit Manager, Staff

AND PLAN	of Correction	(X1) PROVIDER/SUPPLIER/SLIA IDENTIFICATION NUMBER:	(X2: MULTIPLE CONSTRUCTION A. FILILDING		(X9) DA	(X9) DATE SURVEY COMPLETED	
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j	PROVIDER OR SUPPLIER	OF CHATTANOOGA		STREETADDRESS, CITY, STATE, ZIP COL 8249 STANDIFER GAP ROAD CHATTANOOGA, T'N 37421	DE 01	/19/2017	
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F 514	(6) The medical rec	ord must contain-	F 514	Continued from page 8 Development, Activities, Med Director, Social Services, Mai Director, Dietary Manager an	ntenance		
	(ii) A record of the n	ation to identify the resident; esident's assessments; sive plan of care and services		Minimum Data Set Coordinate F514 483.70(i)(1)(5) Res Reco Complete/Accurate/Accessil	or.	2/17/17	
	(iv) The results of a and resident review determinations cond	flucted by the State;		Resident #36 no longer res the facility. Resident #134 no longer	1		
	(vi) Laboratory, radioservices reports as This REQUIREMEN by: Based on medical radioservices facility failed to raccurately document residents (#36 and for care and treatments)	clogy and other diagnostic required under §483,50, equired under §483,50, etc. is not met as evidenced ecord review and interviews, naintain a complete and ted clinical record for 2 existents reviewed.		2. The Director of Clinical Servand/or Nursing Supervisor retained last 30 days of Medication Administration Records, Treat Records for omissions 1/30/2 Issues identified were address the Director of Clinical Services	viewed tment 017.		
	The findings include Medical record revie admitted to the facili including Polyostees Staphylococcus aure Walking, Muscle We Osteoporosis, Cogni	d: w revealed Resident #36 was ty on 3/10/15 with diagnoses with this, Methicilin-resistant eus (MRSA), Difficulty sakness, Chronio Pain, tive Deficit, Diabetes Meilitus n, Atrial Fibriliation, and		3. The Director of Clinical Servand/or Nursing Supervisor in sourcent Licensed Nurses on admedical records, no omissions medical record 2/8/2017-2/15. The Director of Clinical Service Nursing Supervisor will perform Quality Improvement Monitor residents Medication Adminis	curate in the i/2017. es and/or m		

AND PLAN	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA		W HAILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445205	B. 17/NG	•		
CONSU	PROVIDER OR SUPPLIER -ATE HEALTH CARE (1 4	STREET ADDRESS, CITY, STATE, ZIP CODE 9249 STANDIFER GAP ROAD CHATTANOCGA, TN 37421	01/19/2017	
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	Medical record revision 9/1/16 - 9/30/16 knee: Clean with N/Apply 1 inch Idoform with abd Iabdominal Ievery other day" Treatment Record redocumented on 9/23 no documentation for was due to be changed interview with Licens on 1/12/17 at 9:00 A Station, confirmed the every other day, but daily, depending on a Further interview with the treatment was conditioned by 1/18/17 at 9:10 AM, if wound care for Residual Commented. Interview with the Dis 1/18/17 at 9:10 AM, if wound care should heast every other day 9/25/16, making the surgery of the Digest Intestines, Obesity, Neptension, Atrial Fobstructive Pulmona Generalized Anxiety if Medical record review	aw of the Treatment Record revealed "L [left] posterior [s [normal saline] pat dry: a packing into wound. Cover [l pad and tape. Change QOD Continued review of the evealed wound care was a and 9/26/16, but there was pre 9/25/16, a date the dressing ged. Bed Practical Nurse (LPN) #9 [M. at the West Wing Nurses are dressing was changed at times required changing the amount of drainage. In LPN #9 confirmed "I know" purpleted, but was not always be dressed for another office, confirmed the dent #36 was documented on and the documentation for ave been documented at which would have included documentation 1 day late. In revealed Resident #134 actility on 8/4/16 with Eurgical Aftercare Following live System, Fistula of lajor Depressive Disorder, Fibrillation, Chronic ry Disease (COPD), and	F 514	Record and Treatment Record for omissions beginning 2/14/17, 5 that week for 1 month, 3 times a week for 1 month, 2 times a week for 1 month and then monthly thereaft for one year. 4. The Director of Clinical Services introduced the plan of corrections the Quality Assurance Performance improvement Committee on 2/10/2017. The results of this quality Assurance Performance improvement Committee member monthly for three months then quarterly thereafter for a year. The Quality Assurance Performance improvement Committee member consist of but not limited to the Executive Director, Director of Clinic Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenar Director, Dietary Manager and Minimum Data Set Coordinator.	imes sek to ter fity s ical	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/02/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO, 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X8) DATE SURVEY A. BUILDING ___ COMPLETED 445205 B. IVING NAME OF PROVIDER OR SUPPLIER 01/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE CONSULATE HEALTH CARE OF CHATTANDOGA 8249 STANDIFER GAP ROAD CHATTANOOGA, TN 87421 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE FREFIX TAG DAT. DEFICIENCY) F 514 Continued From page 10 F 514 order dated 9/16/16 revealed "...wnd [wound] vac to be changed q [every] 3-4 days. Cleanse wnd cleanser, apply black foam wind bed and secure plastic drape deg [dressing]..." Medical record review of the 9/16 and 10/16 Treatment Records revealed no documentation of wound vac changes from 9/23/16 through 10/5/16 (12 days). An undated sticky note was attached to the 10/16 Treatment Record, with LPN #8's signature, which stated "Refused to be changed states she wants to wait till Monday to change..." Telephone interview with LPN #9 on 1/17/17 at 12:06 PM, confirmed the resident did refuse dressing changes at times and only wanted it done if it was "absolutely necessary." Continued interview confirmed the treatment records were not accurately documented when the treatments were done and when the resident refused. Interview with the Regional Director of Clinical Services on 1/17/17 at 12:30 PM, in the Conference Room, confirmed there was no documentation of wound vac changes for Resident #134 from 9/23/16 through 10/5/16 (12 days). F 520 483.75(g)(1)(l)-(iii)(2)(i)(ii)(h)(i) QAA F520 483.76(g)(1)(i)-(iii)(2)(i)(fi)(h)(i) F 520 2/17/17 COMMITTEE-MEMBERS/MEET 88=G QAA Committee-Members/Meet QUARTERLY/PLANS Quarterly/Plans (g) Quality assessment and assurance. Facility has Quality Assurance (1) A facility must maintain a quality assessment Performance Improvement committee and assurance committee consisting at a in place and implements plans for minimum of: improvement and monitors and (i) The director of nursing services; revises as needed through the QAPI process.

PRINTED: 02/02/2017 FORM APPROVED

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2- MULTIPLE CONSTRUCTION			<u> </u>	
יאורם נפוית	ND PLAN OF DORRECTION NUMBER:		A. E.UILBING			(X3) DATE SURVEY COMPLETED	
NAME OF	445205		B. WING			MOIODAT	
CONSU	PROVIDER OR SUPPLIER LATE HEALTH CARE	of Chattanooga		STREET ADDRESS, CITY, STATE, ZIP COD 8249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421	B 01	<u>/19/2017</u>	
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F 520	1	ge 11 ector or his/her designee;	F 520	Continued from page 11 2. The Regional Director of Cli Services re-educated the	nical		
	(III) At least three of staff, at least one of administrator, owner individual in a leader (g)(2) The quality at committee must: (I) Meet at least qualitying issues we assessment and expendentifying issues we assessment and expendentify and improve the contract of the contract in the contract i	ther members of the facility's f who must be the		interdisciplinary team member regulation F520 and the facility and procedures for Quality Assembly Performance Improvement on 2/9/2017. Observations of curresidents at risk for falls was completed 2/6/2017-2/9/2017 validate current fall intervention based on the care plan were in place by the Director of Services and/or Nursing Supervices and/or Nursing Supervices and/or Nursing Supervisor reviewed the last 30 Medication Administration Records for omission 1/30/2017. Issues identified we addressed by the Director of Cl	y's policy surance frent to ons of Clinical visor. tor of g o days of cords, ns		
	committee to identify deficiencies will not sanctions. This REQUIREMEN by: Based on review of medical record reviet falled to ensure an e (QA) program that reconcern with preven	faith attempts by the vand correct quality be used as a basis for T is not met as evidenced Provider History Profile, ew, and interview, the facility effective Quality Assurance ecognized an engoing ting falls and accurate a QA committee falled to		Services. 3. The Director of Clinical Services and/or Nursing Supervisor in securrent Certified Nurse Assistant Licensed Nurses on making surfall interventions are in place or residents at risk for falls based care plan/kardex 2/8/2017-2/1.	ces erviced nts, e that n		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA
AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	QCZ MULTIPLE CONSTRUCTION A. E UILDING		(X3) D/), 0938-0391 TE SURVEY MPLETED	
NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE (VAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF CHATTANOOGA			TADDRESS, CITY, STATE, ZIP CODE	01	/19/2017
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	, iò		TANOOGA, TN 37421 PROVIDER'S PLAN OF CORRE	стюк	(X6)
TAG REGULATORY OR L	SC (DENTIFYING INFORMATION)	PREFI	<u>*</u>	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE ROPRIATE	(X6) COMPLETION DATE
consistently followed concerns. The facility program was effective deficiencies at F-32 falled to prevent accomit a head laceration. The findings include Review of the Provide 12/12/16 revealed the during the annual Reflect to place to prevent falls F-514 was cited during the annual Reflect to place to prevent falls F-514 was cited during the annual Reflect to place to prevent falls F-514 was cited during the annual Reflect to place to prevent falls F-514 was cited during the annual Reflect to place to prevent falls and 2 resident for management of sealdent (#1) receiving (#48) with an observed place, and 2 resident accurate documentate 45 residents reviewed interview with the Reflect to place and the Admitted to place and safety devices and safety deviced and safety deviced that not identified incomits.	d processes were in place and d by staff to address quality lity falled to ensure the QA we in preventing repeat 3 and F-514. The facility sidents, which resulted in a fall on (Harm) for Resident #1. de: der History Profile dated the facility was cited F-323 accritication survey on ensure interventions were in a. Continued raview revealed ing the annual Recertification and 1/27/16, for failure to and accurate medical accurate medical accurate resident in a fail with injury, 1 resident ation of a safety device not in the medical record of light in the medical record of	F	Put on Dev The Nur Quaresi inte 2/1/3 tir wee ther of C Supe Nurs no o 2/8/Clini Supe Impr Med Treat begin 1 mo 2 tim mont	ure employees will be in serthis during orientation by the velopment Coordinator. Director of Clinical Services sing Supervisor will performality Improvement Monitoring dents at risk for falls for fall serventions being in place beging the place begins the pla	e Staff and/or and or a	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/02/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <u>OMB NO 0938-</u>0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: a building _ 445208 B. VING 01/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CONSULATE HEALTH CARE OF CHATTANOOGA CHATTANOOGA, TN 37421 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX JD PREFIX PROVIDER'S PLAN OF CORRECTION (X6). COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG :AG DEFIG(ENCY) Continued from page 13 F 520 Confinued From page 13 F 620 Assurance Performance Improvement Refer to F282, F328, F514 Committee on 2/10/2017. The results of this quality monitoring will be reported to the Quality Assurance Performance Improvement Committee members monthly for three months then quarterly thereafter for a year. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager and Minimum Data Set Coordinator.